

NORTH IDAHO DERMATOLOGY
2288 Merritt Creek Loop ~ Coeur d'Alene, ID 83814
PH: (208)665-7546 / FAX: (208)667-4607
Website: niderm.com

AS of 04/01/08 there will be a \$10.00 charge with 10 cents per page for copying complete records
Please Initial That You Have Read The Above Charges: _____

AUTHORIZATION TO RELEASE/REQUEST MEDICAL INFORMATION

Patient Name: _____

Birth Date: _____ Social Security#: _____ Phone: _____

I authorize North Idaho Dermatology – 2288 N. Merritt Creek Loop – CDA, ID 83814 to **(circle one)**
release or request my medical, dermatological, and/or lab records to/from:

(NAME/OFFICE)

(ADDRESS)

_____/_____ \$ _____
(PHONE #) / (FAX #)

Would you like your records Faxed – Emailed – Mailed? Please Circle One.

Email Address: _____

Please Check All That Apply:

() All Medical Records (or specify Dates): _____

() All Dermatological (or specify Dates): _____

() All Laboratory, Pathology (or specify Dates): _____

() Other (s): _____

READ THE FOLLOWING CAREFULLY:

I understand that my express consent is required for the Supplier to release information relating to a sexually transmitted disease, mental illness, psychiatric treatment, and/or alcohol abuse, and/or medical records relating to such diagnosis, testing or treatment. I understand that the Supplier cannot limit or control the subsequent use of dissemination of medical information by the party to whom I request the information be furnished. This request is a free and voluntary act by me. I hereby release the Supplier and its staff from all legal responsibility that may arise from the release of the medical information hereby authorized. This authorization is valid for ninety (90) days. A photocopy of the Authorization may be used for all purposes as an original.

Patient's/Legal Guardian's Signature

Today's Date